

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH Facility ID Number:</b> <u>0038679</u></p> <p><b>Facility Name:</b> <u>Park Haven Care Center</u></p> <p><b>Address:</b> <u>107 S. Lincoln</u> <u>Smithton</u> <u>62285</u>  Number City Zip Code</p> <p><b>County:</b> <u>Saint Clair</u></p> <p><b>Telephone Number:</b> <u>(618) 235-4600</u> <b>Fax #</b> <u>(618) 235-5829</u></p> <p><b>IDPA ID Number:</b> <u>95-2301514017</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>12/31/85</u></p> <p><b>Type of Ownership:</b></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Kim Mapes</u> <b>Telephone Number:</b> <u>(877) 823-8375 ext. 4389</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____ <u>03/28/03</u> (Date)</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>Greg Swartz</u></td> </tr> <tr> <td></td> <td>(Title) <u>Director - Medicaid Reimbursement</u></td> </tr> <tr> <td><b>Paid Preparer</b></td> <td>(Signed) _____ (Date)</td> </tr> <tr> <td></td> <td>(Print Name and Title) _____</td> </tr> <tr> <td></td> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u></td> </tr> </table> <p style="text-align: center;"><b>MAIL TO: OFFICE OF HEALTH FINANCE</b>  <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____ <u>03/28/03</u> (Date)		(Type or Print Name) <u>Greg Swartz</u>		(Title) <u>Director - Medicaid Reimbursement</u>	<b>Paid Preparer</b>	(Signed) _____ (Date)		(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																					
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## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Park Haven Manor# 30072 Report Period Beginning: 01/01/02 Ending: 12/31/02

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>0</u>	Skilled (SNF)	<u>0</u>	<u>0</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>101</u>	Intermediate (ICF)	<u>101</u>	<u>36,865</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>101</u>	TOTALS	<u>101</u>	<u>36,865</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>28,260</u>	<u>1,409</u>		<u>29,669</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>28,260</u>	<u>1,409</u>		<u>29,669</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.48%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 &amp; 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/31/85

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/31/85 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number of beds certified 0 and days of care provided 0Medicare Intermediary United Government Services

## IV. ACCOUNTING BASIS

MODIFIED  
ACCRUAL ☒ CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Park Haven Manor

#

30072

Report Period Beginning:

01/01/02

Ending:

12/31/02

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	115,369	4,572	1,480	121,421	3,359	124,780		124,780		1
2	Food Purchase		98,989		98,989		98,989	(2,777)	96,212		2
3	Housekeeping		367	82,210	82,577		82,577	(985)	81,592		3
4	Laundry		3,639	52,000	55,638		55,638	838	56,476		4
5	Heat and Other Utilities			68,469	68,469		68,469	(3,930)	64,539		5
6	Maintenance	18,134	7,753	28,962	54,849	1,755	56,604	(249)	56,355		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	133,504	115,319	233,121	481,945	5,114	487,059	(7,103)	479,956		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	736,736	33,813	11,329	781,879	60,176	842,055	(1,659)	840,396		10
10a	Therapy		62		62	(62)	(0)		(0)		10a
11	Activities	35,183	3,880		39,063		39,063	328	39,391		11
12	Social Services	122,924	2,944	5,683	131,550	1,430	132,980	(5,149)	127,831		12
13	Nurse Aide Training			(4,182)	(4,182)		(4,182)	7,610	3,428		13
14	Program Transportation			1,042	1,042		1,042	(74)	968		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	894,843	40,699	17,472	953,014	61,544	1,014,558	1,056	1,015,614		16
	<b>C. General Administration</b>										
17	Administrative			230,315	230,315	(4,491)	225,824	35,385	261,209		17
18	Directors Fees										18
19	Professional Services			727	727		727		727		19
20	Dues, Fees, Subscriptions & Promotions			20,373	20,373	(1,365)	19,008	1,009	20,017		20
21	Clerical & General Office Expenses	120,814	6,763	23,907	151,484	(60,802)	90,682	(28,615)	62,067		21
22	Employee Benefits & Payroll Taxes			176,039	176,039		176,039	(218)	175,821		22
23	Inservice Training & Education			181	181		181		181		23
24	Travel and Seminar			3,771	3,771		3,771	(54)	3,717		24
25	Other Admin. Staff Transportation			998	998		998		998		25
26	Insurance-Prop.Liab.Malpractice			70,253	70,253		70,253	40,069	110,322		26
27	Other (specify):*		(1,074)	(823)	(1,896)		(1,896)	2,292	396		27
28	<b>TOTAL General Administration</b>	120,814	5,689	525,741	652,245	(66,658)	585,587	49,868	635,455		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,149,161	161,708	776,335	2,087,203		2,087,203	43,821	2,131,024		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Park Haven Manor

30072

Report Period Beginning:

01/01/02

Ending:

12/31/02

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			45,387	45,387		45,387	5,148	50,535			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			57	57		57	350	407			32
33	Real Estate Taxes			44,136	44,136		44,136	323	44,459			33
34	Rent-Facility & Grounds			185,644	185,644		185,644		185,644			34
35	Rent-Equipment & Vehicles			20,487	20,487		20,487	(174)	20,313			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			295,712	295,712		295,712	5,647	301,359			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							51,692	51,692			42
43	Other (specify):*		2,839		2,839		2,839		2,839			43
44	<b>TOTAL Special Cost Centers</b>		2,839		2,839		2,839	51,692	54,531			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,149,161	164,547	1,072,047	2,385,754		2,385,754	101,160	2,486,914			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Park Haven Manor

# 30072

Report Period Beginning: 01/01/02

Ending: 12/31/02

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(2,755)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(23)	2		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	3,018	27		18
19 Entertainment				19
20 Contributions	(100)	20		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(7,936)	21		24
25 Fund Raising, Advertising and Promotional	(916)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(189)	20		28
29 Other-Attach Schedule	(4,373)	5A		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (13,274)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
Amortization of Organization & Pre-Operating Expense			33
33 Adjustments for Related Organization Costs (Schedule VII)	36,854	17	34
34 Other- Attach Schedule	77,580		35
35 SUBTOTAL (B): (sum of lines 31-35)	\$ 114,434		36
(sum of SUBTOTALS			
36 TOTAL ADJUSTMENTS (A) and (B) )	\$ 101,160		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Park Haven ManorID# 30072Report Period Beginning: 01/01/02Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	UR Fees	\$ 0		1
2	Barber & Beauty			2
3	Patient Loss	(94)	27	3
4	Vendor Service Charge	(2,101)	27	4
5	Bank Service Charge	(616)	21	5
6	Magical Moments	0	20	6
7	Additional Facility Rent	0	34	7
8	Corporate Collection Fees	(1,562)	21	8
9	Patient Personal Supplies Sold	0	02	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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32				32
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,373)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Park Haven Manor# 30072

Report Period Beginning:

01/01/02

Ending:

12/31/02**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,777)	0	0	0	0	0	0	0	0	0	0	(2,777)	2
3	Housekeeping	(985)	0	0	0	0	0	0	0	0	0	0	(985)	3
4	Laundry	838	0	0	0	0	0	0	0	0	0	0	838	4
5	Heat and Other Utilities	(3,930)	0	0	0	0	0	0	0	0	0	0	(3,930)	5
6	Maintenance	(249)	0	0	0	0	0	0	0	0	0	0	(249)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(7,103)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,103)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,659)	0	0	0	0	0	0	0	0	0	0	(1,659)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	328	0	0	0	0	0	0	0	0	0	0	328	11
12	Social Services	(5,149)	0	0	0	0	0	0	0	0	0	0	(5,149)	12
13	Nurse Aide Training	7,610	0	0	0	0	0	0	0	0	0	0	7,610	13
14	Program Transportation	(74)	0	0	0	0	0	0	0	0	0	0	(74)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>1,056</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,056</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	35,385	0	0	0	0	0	0	0	0	0	0	35,385	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	1,009	0	0	0	0	0	0	0	0	0	0	1,009	20
21	Clerical & General Office Expenses	(28,615)	0	0	0	0	0	0	0	0	0	0	(28,615)	21
22	Employee Benefits & Payroll Taxes	(218)	0	0	0	0	0	0	0	0	0	0	(218)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(54)	0	0	0	0	0	0	0	0	0	0	(54)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	40,069	0	0	0	0	0	0	0	0	0	0	40,069	26
27	Other (specify):*	2,292	0	0	0	0	0	0	0	0	0	0	2,292	27
28	<b>TOTAL General Administration</b>	<b>49,868</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>49,868</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>43,821</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>43,821</b>	<b>29</b>

## Summary B

**Ending:** 12/31/02

[illegible]

Facility Name & ID Number Park Haven Manor# 30072

Report Period Beginning:

01/01/02

Ending:

12/31/02

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Beverly Health & Rehabilitation Services	100	More than 400 facilities throughout the U.S.		Aegis Therapies, Inc.	Fort Smith, AR	Therapy
				Ceres Strategies, Inc.	Fort Smith, AR	Purchasing

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Home Office Costs	204,928	Beverly Health & Rehabilitation Services	100.00%	\$ 200,407	\$ (4,521)	1
2	V	10	Nursing Consultant	25,387	Beverly Health & Rehabilitation Services	100.00%	60,504	35,117	2
3	V	01	Dietary Consultant	0	Beverly Health & Rehabilitation Services	100.00%	3,359	3,359	3
4	V	12	Social Services Consultant	0	Beverly Health & Rehabilitation Services	100.00%	1,430	1,430	4
5	V								5
6	V	10a	Therapy Expense/Home Office	0	Aegis Therapies, Inc.	100.00%	0		6
7	V	27	Home Office Costs	0	Ceres Strategies, Inc.	100.00%	1,469	1,469	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 230,315			\$ 267,169	\$ * 36,854	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Park Haven Manor # 30072 Report Period Beginning: 01/01/02 Ending: 12/31/02

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

**Page 7 - N/A**

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Park Haven Manor# 30072

Report Period Beginning:

01/01/02

Ending:

12/31/02

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Beverly Health & Rehabilitation ServicesStreet Address One Thousand Beverly WayCity / State / Zip Code Fort Smith, AR 72919Phone Number ( 479) 201-2000Fax Number ( 479) 201-4302

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Corp Home Office/QA Cost	Resident Days	87,626	3	\$ 591,874	332,946	29,669	\$ 200,401
2									2
3	10	Corp Home Office Cost-Nursing	Resident Days	87,626	3	73,317	0	29,669	24,824
4	10	Corp QA Cost - Nursing	Resident Days	87,626	3	105,310	9,192	29,669	35,657
5									5
6	01	Corp QA Cost - Dietary	Resident Days	87,626	3	9,920	3,610	29,669	3,359
7									7
8	12	Corp QA Cost - Social Services	Resident Days	87,626	3	4,224	2,497	29,669	1,430
9									9
10	10a	Therapy/Home Office	Facility Specific		2	378,623	0	0	0
11									11
12	27	Corp Home Office	Facility Specific		3	5,333	0	0	1,469
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24		Rounding							29
25	TOTALS					\$ 1,168,601	\$ 348,245		\$ 267,169

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3	CCA Financial, Inc.		X	Equipment Acquisition							407	3	
4	(Turbolan)											4	
5												5	
	Working Capital												
6												6	
7	Interest Income		X									7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 407	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 407	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$ 5,929

Line # 34

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Park Haven Manor**# **30072** Report Period Beginning: **01/01/02** Ending: **12/31/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2001 report.		\$ 24,101	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 44,459	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 20,358	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 24,101	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 44,459	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997 38,032 8		
	1998 38,209 9		
	1999 39,397 10		
	2000 42,505 11		
	2001 44,459 12		
		<b>FOR OHF USE ONLY</b>	
		13 FROM R. E. TAX STATEMENT FOR 2001 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Park Haven Manor COUNTY Saint Clair

FACILITY IDPH LICENSE NUMBER 95-2301514017

CONTACT PERSON REGARDING THIS REPORT Kim Mapes

TELEPHONE (877) 823-8375 ext. 4389 FAX #: (479) 201-4302

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>01139138</u>	<u>Encore Park Haven IL LLC</u>	\$ <u>44,459.08</u>	\$ <u>44,459.08</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>44,459.08</u></u>	\$ <u><u>44,459.08</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?           YES      X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:
21,282

B. General Construction Type:

Exterior
Brick

Frame
Wood

Number of Stories
One

C. Does the Operating Entity?

☐ (a) Own the Facility
☐ (b) Rent from a Related Organization.
☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1985	\$	1
2					2
3	TOTALS			\$	3

Facility Name &amp; ID Number Park Haven Manor

# 30072

Report Period Beginning:

01/01/02

Ending:

12/31/02

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1985		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	LEASEHOLD IMPROVEMENTS			1993	52,443	4,353	5-20	4,353		49,034	10
11	(See depreciation schedule for asset detail of items)			1994	27,057	569	5-20	569		25,094	11
12				1995	13,241	805	5-20	805		7,457	12
13				1996	2,711	198	5-20	198		1,218	13
14				1997	100,410	8,927	5-20	8,927		48,404	14
15				1998	21,341	1,363	5-20	1,363		5,982	15
16				1999	8,584	895	5-20	895		3,135	16
17				2000	8,561	605	5-20	605		1,521	17
18				2001	63,250	6,325	5-20	6,325		9,452	18
19				2002	33,481	1,227	5-20	1,227		1,227	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 331,079	\$ 25,267		\$ 25,267	\$	\$ 152,524	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 207,320	\$ 18,656	\$ 18,656	\$	5-10	\$ 129,349	71
72	Current Year Purchases	22,519	6,611	6,611		5-10	1,529	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 229,840	\$ 25,268	\$ 25,268	\$		\$ 130,878	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 560,919	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,535	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 50,535	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 283,402	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Facility Renovation	\$ 49,395	92
93			93
94			94
95		\$ 49,395	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: Encore Retirement Centers, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>101</u>	<u>12/31/85</u>	\$ <u>185,644</u>	<u>5</u>	<u>30</u>	3
4	Additions							4
5								5
6								6
7	TOTAL		<u>101</u>		\$ <u>185,644</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☒ YES ☐ NO Terms: Purchase of all Encore facilities \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$                      Description: See attached schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Facility</u>	<u>2000 Ford</u>	\$ <u>571</u>	\$ <u>6,854</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>571</u>	\$ <u>6,854</u>	21

10. Effective dates of current rental agreement:

Beginning 12/31/01  
Ending 12/31/06

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending      Annual Rent

12. 12/31/03 \$ 265,637  
13. 12/31/04 \$ 265,637  
14. 12/31/05 \$ 265,637

\* If there is an option to buy the building,  
please provide complete details on attached  
schedule.

\*\* This amount plus any amortization of lease  
expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input checked="" type="checkbox"/>  HOURS PER AIDE <u>90</u>	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input checked="" type="checkbox"/>  HOURS PER AIDE <u>39</u>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$ 1,178	\$ 1,938		\$ 3,116
2	Books and Supplies	162	150		312
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$ 1,340	\$ 2,088	\$	\$ 3,428
10	SUM OF line 9, col. 1 and 2 (e)	\$ 3,428			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	5
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	<b>5</b>

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
							hrs	\$			
1	Licensed Occupational Therapist										2
2	Licensed Speech and Language Development Therapist										3
3	Licensed Recreational Therapist										4
4	Licensed Physical Therapist										5
5	Physician Care										6
6	Dental Care										7
7	Work Related Program										8
8	Habilitation										9
9	Pharmacy										10
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										11
11	Academic Education										12
12	Exceptional Care Program										13
13	Other (specify):										14
14	TOTAL										

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,348	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,980 )	472,064		3
4	Supply Inventory (priced at Historical Cost )	26,852		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	29,500		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 531,763	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable	77,561		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	49,395		14
15	Leasehold Improvements, at Historical Cost	331,079		15
16	Equipment, at Historical Cost	229,840		16
17	Accumulated Depreciation (book methods)	(283,402)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 404,473	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 936,236	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 74	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,066		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,415		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,101		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Contingencies</u>			36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 105,656	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Intercompany</u>	(112,190)		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ (112,190)	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ (6,534)	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 942,770	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 936,236	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>799,450</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Remove 2001 Home Office Equity Adjustment</b>	<b>287,281</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,086,731</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(143,961)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Cost Report Equity Adjustments</b>	<b>0</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(143,961)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>942,770</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

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**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,306,673	1
2	Discounts and Allowances for all Levels	(67,635)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,239,038	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	7,610	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,670	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 9,280	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Net Vending, Pat Pers Needs, Other Misc. Rev</b>	1,085	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,085	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,249,403	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	481,945	31
32	Health Care	960,624	32
33	General Administration	652,245	33
<b>B. Capital Expense</b>			
34	Ownership	295,712	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	(48,853)	35
36	Provider Participation Fee	51,692	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,393,364	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(143,961)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (143,961)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	6,339	7,120	\$ 133,711	\$ 18.78	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	5,999	6,552	132,676	20.25	3
4	Licensed Practical Nurses	10,772	11,469	158,650	13.83	4
5	Nurse Aides & Orderlies	31,806	35,499	309,175	8.71	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	3,826	4,276	35,563	8.32	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	3,979	4,375	52,356	11.97	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	13,281	14,476	113,066	7.81	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,426	1,642	16,974	10.34	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	1,936	2,080	60,802	29.23	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	3,192	3,646	32,478	8.91	22
23	Office Manager	636	678	6,866	10.12	23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	6,134	6,536	80,286	12.28	28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,848	1,938	16,561	8.55	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	91,174	100,286	\$ 1,149,161 *	\$ 11.46	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 1,480	1-3	35
36	Medical Director		3,600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		5,454	10-3	39
40	Physical Therapy Consultant		0	N/A	40
41	Occupational Therapy Consultant		0	N/A	41
42	Respiratory Therapy Consultant		0	N/A	42
43	Speech Therapy Consultant		0	N/A	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		5,641	12-3	45
46	Other(specify)		134,210	3,4	46
47			15,393	6	47
48			611	6,19	48
49	TOTAL (lines 35 - 48)		\$ 166,390		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

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## XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description			Description	Amount
Melvin Zimmerman	Executive Director	0	\$ 60,802	Workers' Compensation Insurance	\$ 10,072		IDPH License Fee	\$ 242
				Unemployment Compensation Insurance	0		Advertising: Employee Recruitment	11,755
				FICA Taxes	0		Health Care Worker Background Check	2,265
				Employee Health Insurance	65,296		(Indicate # of checks performed 0)	
				Employee Meals	0		Dues and Subscriptions	5,697
				Illinois Municipal Retirement Fund (IMRF)*	0		Advertising and Public Relations	2,411
				Employee Injury	0		Community Education	0
TOTAL (agree to Schedule V, line 17, col. 1)				Payroll Taxes	97,123			
(List each licensed administrator separately.)			\$ 60,802	Retirement Expense	783		Reclass Miscoded Expense	(1,365)
B. Administrative - Other				Employee Fringe Benefits	1,374		Less: PAC Fees	(485)
Description			Amount	Workers' Compensation Insurance Adjustment	2,342		Less: Public Relations Expense	( )
			\$	Medical/Dental Ins Adjustment	(1,170)		Non-allowable advertising	(314)
				Rounding	0		Yellow page advertising	(189)
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 175,821	TOTAL (agree to Sch. V, line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)								
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Corporation Service Co. Inc.	Legal		\$ 116				Out-of-State Travel	\$
HR Solutions	Human Resource		251					
Deloitte & Touche, LLP.	Accounting		360				In-State Travel	3,304
							Meals	414
							Personal ED Travel	
							Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense	( )
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 727				(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 3,717

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

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## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association \$5,350
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? Various
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,692  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,755
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 50%  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ernst & Young, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Report not available before Cost Report due date.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.